DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1168 (Rev. 04/02)

STATE OF WISCONSIN

REQUEST FOR UNIQUE SUFFIX NUMBER FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME, VENTILATOR-DEPENDENT, OR BRAIN INJURY CASES

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Completion and retention of this form is required under s. 7000 of the Hospital Inpatient State Plan. Failure to complete and submit this form may result in denial of Medicaid payment for the services.

INSTRUCTIONS

1. Type or print clearly.
2. Check the box to indicate which suffix number(s) is being requested.
3. The Wisconsin Medicaid provider number must be the first six digits of your provider number plus the two-digit suffix number. Use the chart below for the appropriate suffix number.
4. For more information on obtaining suffix numbers, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

Type of Service	Suffix Number	Check Desired Categories
Acquired Immune Deficiency Syndrome (AIDS) — acute care	01	☐
AIDS — extended care	02	☐
Ventilator — long-term services	04	☐
Brain injury — out-of-state	80	☐
Brain injury — neuro-behavioral	81	☐
Brian injury — coma-stem	82	☐

Name — Provider	Wisconsin Medicaid Provider Number (eight digits)

Check the pertinent options below:

☐ This facility plans to request the special payment rate for services provided to recipients with Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection in the future.

☐ This facility has an inpatient unit devoted solely to the care of recipients who are ventilator dependent and requests to be assigned the appropriate suffixes for the special payment rate for services provided to ventilator-dependent recipients in the future.

☐ This facility does not have an inpatient unit devoted solely to the care of recipients who are ventilator dependent and requests to be assigned the appropriate suffixes for the special payment rate for services provided to ventilator-dependent recipients in the future.

☐ This facility plans to request the special payment rate for services provided to recipients with brain injury in the future.

SIGNATURE — Authorized Hospital Staff Member	Date Signed

Mail completed forms to the following address:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Reset Form